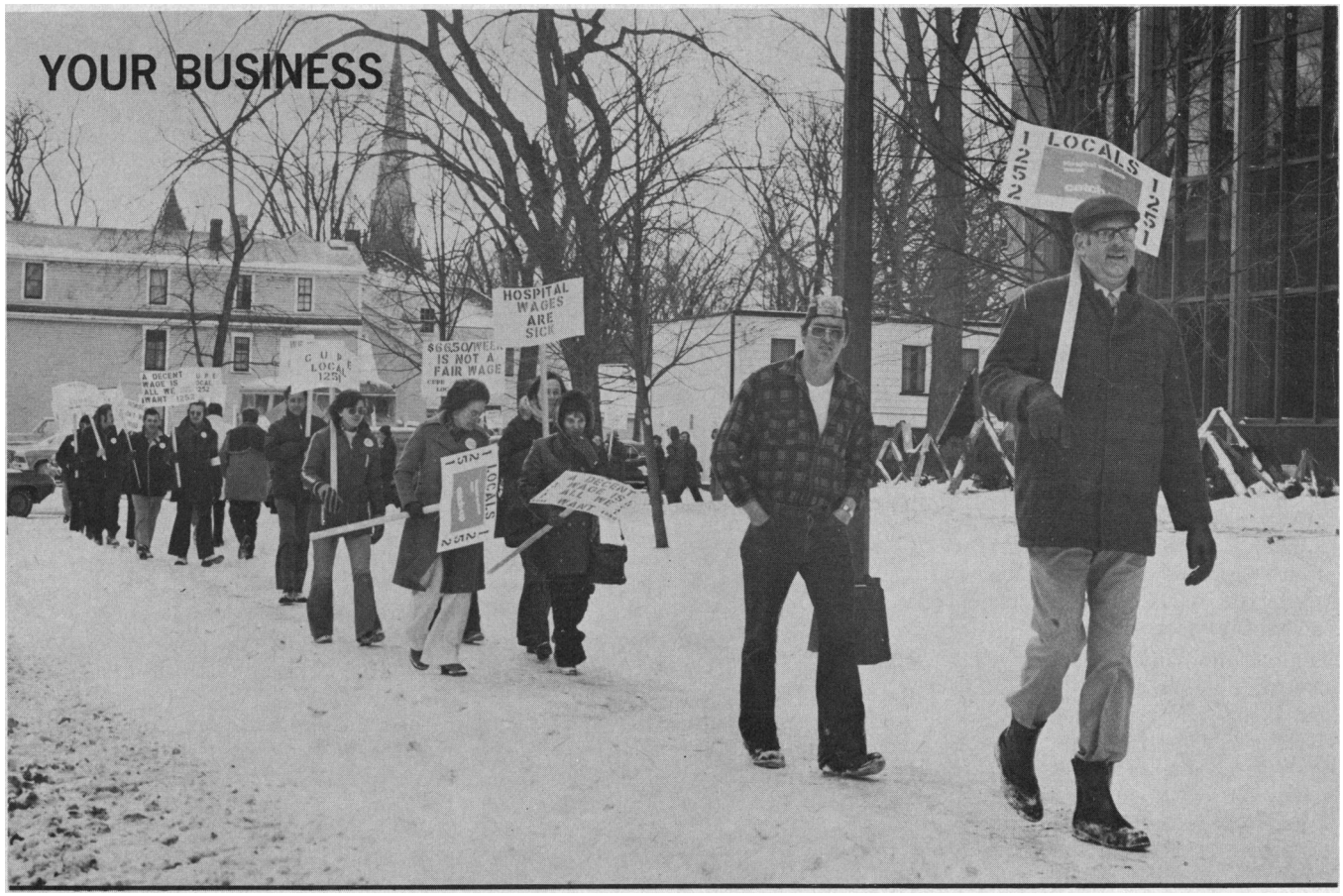


Unions moving into MD offices and clinics

By David Woods

Marx's exhortation to the workers of the world — unite — went largely unheeded by Canada's health workers, at least until fairly recently. And anything even approaching a strike would have been considered unthinkable, not to mention illegal, until a few years ago.

But times have changed. Those in our so-called health industry who haven't actually taken strike action have at least threatened it: doctors, nurses, residents and interns, hospital orderlies and cleaners among them.

It's probably precisely because health care has become an industry that collective bargaining, withdrawal of services, certification, arbitration, picket lines, are — or can be — facts of life for hospitals and clinics today. What was once the exclusive vocabulary of the assembly line now rings clearly through our health institutions.

Whether unionization is a good or a bad thing is really neither here nor there; it's an emotional, polemic issue that seldom produces much unity among those who discuss it. What does matter is that unionization as a fact is very much here; what's needed now is some understanding of how it works — and what it's going to mean in the health institutions.

If unionization came late to the health team it was mainly because there was no one to be united *against*; nobody to bargain *with*.

Government provided that focal point even before it got involved in hospital and medical insurance plans: there was hardly a crack, you will recall, in the solid bond of opposition by Saskatchewan physicians against that province's 1962 proposals to bring on medicare.

In the "bad old days" of free enterprise medicine, doctors could do monetary battle only with their accounts receivable; hospital workers knew that they couldn't take out of the pot more than was in it (and that, usually, wasn't too much); those who toiled in clinics or smaller private practices simply went, Cratchitlike, to ask for a raise when faced with imminent starvation.

Medicare has mercifully changed all that: doctors now get paid promptly, and in coin of the realm instead of apples or eggs, and presumably pass on part of this currency to their employees; hospitals, as in the case of the recent Ontario strike, will be able to meet their higher salary obligations because provincial governments kindly provide the cash.

All very nice. Except that governments — whatever impression they may sometimes give to the contrary — do not have endless financial resources. What government giveth, government taketh away — from somewhere. And in paying the health care pipers it can also of course call their tune. What that means is that government can equally effect economies at the expense of a particular professional or trade group. Hence, be prepared; be strong; be united — be unionized.

As the president of Quebec's Federation of Medical Specialists, Dr. L. R. Robillard, told the Alberta Medical Association's annual meeting last year, the great majority of trade or professional disputes are resolved without resorting to strike action — except where governments are involved. The reason for this, he said, is that "government will not negotiate, they're too powerful. Why should they talk? They don't have to."

Robillard told his audience that the question isn't *whether* physicians should bargain with government — but how to do it most effectively; as he put it, "you've got one thing going for you: these jokers can't operate medicare without you." He described the walk-

outs by Quebec physicians in 1967 and 1970 as "effective".

On that same panel, which was debating the merits of the Alberta Medical Association's functioning as a professional body or as a union, labour lawyer A. O. Ackroyd said that technically the AMA already was a union.

Ackroyd, the association's negotiations consultant at that time, defined a union as "an organization of employees formed for the purpose of regulating relations between employers and employees, which has a written constitution, rules and bylaws setting forth the objects and purposes and defining the conditions under which persons may be admitted as members thereof."

One can discern, even through the turbid prose so beloved of the law (and, come to that, the unions) that this definition would make any provincial medical association a full-fledged union. Except for one minor wrinkle which Ackroyd pointed out and which, in fact, could very quickly be ironed out: physicians are not, strictly speaking, employees. This, he said, could be remedied by amending legislation as was done in New Brunswick in 1970 allowing certain professional groups to be deemed "units of employees appropriate for collective bargaining."

Ackroyd concluded that if a medical association were to become the official bargaining agent for its members, it must be the only such agent. He saw a danger in multiunion membership with, as he put it, the orthopedic surgeons' joining the plasterers' union, or the urologists' joining the plumbers.

Ambivalence

Perhaps the underlying problem in physicians' relationships with government is the ambivalence of those relationships: doctors are partners with government in the implementation of medicare; then they become antagonists at the bargaining table with that same government, over what Dr. Robillard calls the "obscene" question of money — who gets paid what for operating medicare.

The solution, at least in the short term, may be the one adopted by the British Columbia Medical Association. The BCMA has developed a "separation of powers" approach under which a separate negotiating committee, backed up by experts including a labour lawyer and an actuary, maintains regular dialogue with government.

This method at least has the virtues of softening confrontation, encouraging a flow of two-way information and retaining a measure of professional dignity.

But what about the physician as employer? In this position, he must swap roles yet again, changing from oppressed proletariat to mill owner.

More seriously — and more accurately — he plays both parts at once; obviously, he must have some control over his income from government if he is to meet the demands of his employees who are becoming increasingly united.

At one time, as we've seen, raises and working conditions for workers in clinics, groups and other forms of private practice were conducted on a rather genteel, personal basis. Today, with clinic workers' becoming — or attempting to become — unionized, there's every likelihood that the process will be tougher and more organized. And it will gather momentum. As a spokesman for the Canadian Union of Public Employees (CUPE) told me: "We'd like to see every clinic join the union, eventually."

It won't be easy. As the months-long strike at Ontario's Fort Frances Medical Clinic clearly shows, there's much more to the issue than dollars and cents: management attitudes, labour relations and, above all, communication — or the apparent lack of it — play a vital part in this bitter dispute. And so, too, does the question of unionization itself.

Dr. Richard Moulton, one of the clinic's 12 physicians, told the Canadian Association of Medical Clinics meeting earlier this year that while we live in a unionized society he objects to having his staff "bullied into joining a union." Unionization, he said, could lead to a clinic's getting locked into existing patterns of care, and to eventual loss of control by the owners. Moulton also said, "We didn't know we had a problem until it was too late."

The same was obviously true for the clinic's manager, John Stewart, who told the same CAMC meeting that he didn't know there was a strike until he heard about it on his car radio on the way to the clinic, where he encountered a picket line.

For the 20 of 28 workers who struck the Fort Frances clinic, the issue, ostensibly, is wages: nurses' assistants and clerical staff earn considerably less than the rates paid at the local hospital.

But in fact the issue centres on the actual business of unionization itself. Arthur Riseley, CUPE's Ontario regional director, visited Fort Frances and concluded that the clinic's management, in challenging the right of unions to exist, was firmly rooted in the 19th Century.

One might argue convincingly that employers are fully entitled to call the shots; if they don't want a unionized staff, they don't have to have one — the paying-the-piper routine in another medical context.

But while medicare, as Dr. Robillard suggested, couldn't work without the doctors, the Fort Frances clinic appears to have got along quite nicely without its striking employees.

So if union membership and strike action in clinics isn't all that powerful a force, why does unionization engender such fear in the doctor-employer? One must assume that the fears are based on lack of knowledge of the union process, lack of control and concern for where it all might lead.

The first of these apprehensions is unforgivable and possibly dangerous; the second is at least understandable; the third — if you listen to what the union leaders are saying — may be fully justified.

Arthur Riseley, for example, says simply that CUPE's goal is More — and then More. Surely this doesn't mean escalating wage demands to some stratospheric infinity? "Yes," he says, "we'll always want more because every day we're chasing a star — the rising cost of living."

Riseley, a British-born former assembler with the English Electric Company in St. Catharine's, Ont., points proudly to the fact that CUPE has had more militancy and strikes in Ontario than the steelworkers and has succeeded, notably in the settlement reached on behalf of Ontario hospital workers earlier this year, in raising wages significantly (and deservedly) for lower-paid employees such as cleaners and orderlies.

Bargain province-wide

Next, CUPE would like to see provincial bargaining, with all these workers paid a provincially set rate. The money, says Riseley, must come from government — "government must open the pursestrings."

I interviewed Riseley and the man credited with spearheading the "catch-up" campaign to increase hospital wages, Tom Edwards, at CUPE's offices in the Ontario Federation of Labour building in the Toronto suburb of Don Mills. The building houses dozens of unions as well as a sprinkling of capitalistic tenants from the worlds of investment and insurance.

Edwards, also British-born, and a former labourer, masterminded the Toronto hospitals' settlement but credits Ontario Health Minister Frank Miller with "sense", "guts" and "foresight" during the negotiations. He also acknowledges the stand taken by the Ontario Medical Association that workers in hospitals should receive the same wages and conditions as their counter-

parts in other areas of the public service.

Edwards attributes the late dawning of unionization among health workers to the disappearance of what he calls the Florence Nightingale syndrome — a reference to the fact that nurses and other hospital personnel worked long hours for low pay, perhaps out of some vague notion that the reward for "good" work in the service of humanity didn't have to be tangible. Much of the less glamorous work in hospitals today, he points out, is done by foreigners, often very recent immigrants who don't speak our languages.

Both Riseley and Edwards agree that the climate of acceptance of unions in Canada isn't too good; there's less of a union tradition here, they say, compared with Britain, for example, where 70% of the workforce is unionized, in contrast with their figure of around 30% for Canada.*

CUPE, considering it was founded only in September 1963, is doing a lot to change all that. So far as the future is concerned, says Edwards, "I'll be satisfied when every health and hospital worker receives rates of pay and conditions comparable to those (provided by)... the better employers."

"And *then* you ask for more", adds Arthur Riseley.

The right way?

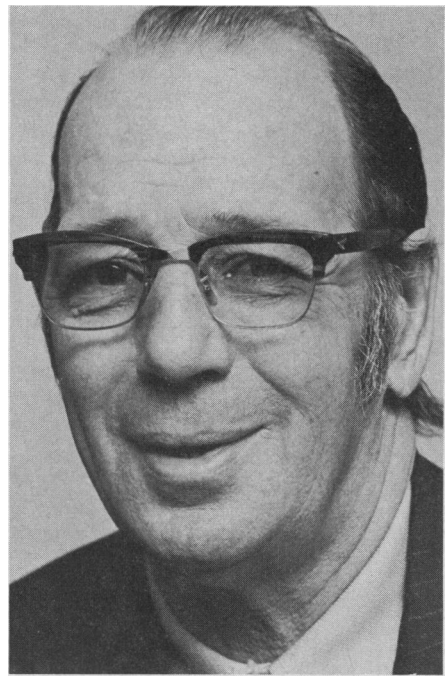
But, for health workers, is unionization necessarily the way to get it? Unlike the worker at General Motors, say, their demands cannot be tied to production and profit.

Bob Miller, personnel director at Toronto's St. Joseph's Hospital, says that he believes unionization is alien to professional and clerical employees; unenlightened management is what usually drives such people into a union, says Miller, and if management doesn't like the thought of that it should take appropriate preventive measures. What measures? Miller's formula is communication — managers who listen as well as talk — and sound personnel policies including a grievance procedure, mechanisms for determining seniority, vacation allotments and so on.

Miller is convinced that, while salary always figures prominently in any labour dispute, it's often a convenient front for deeper, less definable concerns such as recognition, security and some knowledge of the overall machine in which the individual worker may feel he is just a minor and dispensable cog.

Bob Miller came to St. Joseph's 5½ years ago from a personnel position in the aviation industry; at the hospital there are 1800 employees, four unions.

He knows the unions and, as he puts it, "I'm not anti-labour; I'm pro-management."



Riseley: more... then more

How does the bargaining process work? Miller explains that a group of employees decides it wants to be represented by a bargaining agent — usually because of some dissatisfaction along the lines we've discussed, but often finding its focus in finance. The group may then get certification from the provincial department of labour which informs the hospital that Mr. X is the group's representative, and that the hospital or other institution must bargain "in good faith" with Mr. X within so many days.

The personnel director or clinic administrator then calls together a negotiating committee for the institution. The committee should include the organization's finance man (comptroller or accountant) and representatives of the disciplines involved in the dispute.

This committee then meets with the union official, and the bargaining process begins; predictably, it works on an adversary system, and, of course, timing, personalities, poker-playing skills, diplomacy and available funds all influence the result.

Bob Miller, whom I spoke with in the hospital's personnel offices which face a streetcar depot deserted on what was the first day of Toronto's lengthy transport strike, notes, "I don't blame the unions for wanting the moon; I blame others for giving it to them."

Nonetheless, he believes in the importance of giving the worker a say, creating a climate in which he can grow. Doctors, he thinks, don't always find this easy to do because they're naturally authoritarian; they're not used to being questioned.

In the clinic setting, he advises, such physicians would do well to develop communication between administration and employees, to hire clinic managers well versed in personnel relations (or to train existing ones in that skill) and to create an atmosphere in which dissent is considered reasonable.

In bigger institutions, says Miller, dialogue is even more important and, if it can't be as informal as in smaller ones, it can at least be facilitated by using newsletters and notice boards and by ensuring that department heads understand the importance of communication — two-way communication — with their staff.

Financially the clinics, unlike the hospitals, aren't likely to be bailed out by government; and this can create real hardship.

A real bind

As one Ontario clinic manager told me, doctors in that province gained fee increases in May 1971 and again in May of this year; meanwhile most clinic workers have been given raises every year and that, along with the very heavy inflation of the past couple of years, has put some clinics in a real bind. They've had to economize — sometimes by cutting staff.

This creates concern over security and hastens the union process which, this clinic manager thinks, in turn adversely affects the relationship between doctor, patient and clinic worker. He believes the unionization process is "painful and instructive", but probably unnecessary if employees are dealt with in a fair and equitable manner; not only that, he says, but clinic staff must be made aware that they don't *have* to join a union, and that doing so may lead to strikes (and consequent loss of income) as well as outside control.

While it is reasonable to assume that good human relations will lead to good personnel and labour relations there are other factors at work in the unionization process: the herd instinct for one — and political considerations for another.

Since there are more employees (and

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*Messrs. Riseley and Edwards appear to be in disagreement with recent figures of the London *Economist*, which (Sept. 21) observed that "half the industrial workers of Britain are not even members of unions affiliated to the TUC." The *Economist* also cites statistics that show the net result of a recent unparalleled period of militancy by British unions is a 2½% reduction in the real value of their members' incomes. Britain has accordingly replaced Italy as the EEC nation with the lowest standard of living — ED.

CLSCs

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sions concerning purely medical services were to be controlled by those not qualified, the federation would be duty bound to denounce it. I think it is already doing so.

In the meantime, the citizens are not uninformed. The question I ask myself is how all these multiple authorities can work, not against, but with one another on a series of decisions which will enhance the quality of life, especially for those who are the farthest removed from the decisions and from the opportunity of access, not only to health care, but to all the goods and services and values which society has to offer.

The question, therefore, that I ask the federation is this: has the federation, until now, done everything in its power to ensure that the medicine practised in the LCSCs, if it is practised, is of value? Is it not a little arrogant with respect to other health professionals, social service specialists and particularly representatives of the people?

As for the government, it must be recognized as a meaningful partner in the discussions, not only by the working class groups but also by the FMOQ. The newly acquired powers in the health field carry a special responsibility. The actual lack of confidence towards the government will only disappear if the technocrats show their goodwill and adopt a conciliant and flexible attitude, searching for a compromise. They must also be ready to adapt themselves to the different situations and accept without any ulterior motive a certain decentralization of powers. The present lack of communication between the three groups can only come to an end if the government representatives find a suitable solution even for problems which now seem impossible to solve.

If the LCSC experiment ends in failure, many people will hold the doctors primarily responsible. A purely negative attitude at this time on the part of the federation will be unproductive and might be suicidal. The government, responsible to the people as a whole, is pursuing commendable objectives in the field of medical and social services, breaking with medical practice which was, until recently, liberal and individualistic. The department of social affairs will probably agree to terms which open the doors of the LCSCs to citizens' delegates. It will likely do the same for the other health professionals.

If the partners were to reject open-minded cooperation, through inability to grasp in time the significance of the change in the health field, they would find themselves relegated to the sidelines. It happened to the clergy a short while ago and is liable to happen to lawyers and other traditional elites, suddenly dislodged from their ivory towers. The federation would then be heavily accountable to its members. It bears today the burden of proving, and proving realistically, that it can no longer look for anything worthwhile from the LCSCs. Lacking this irrefutable proof, it must reopen the dialogue, on new terms, with the government and the working class groups.

I would like to make a suggestion to the federation. In the face of this evolution, which seems to me inevitable, the medical profession cannot sit idly by. Assume your responsibility wholeheartedly; you must, for the medical profession. Otherwise the profession will be dominated, directed by others, and that bespeaks danger, for the good of the profession and the good of public health.■

MEDICAL COUNCIL

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register. In addition, if a person registered in a province is also registered in the Canadian Medical Register and if the provincial licensing authority removes his provincial licence, the council will, without further enquiry, direct that his name be erased from our register. If you read the Canada Medical Act, you will see that there are rights of appeal and provision for the registrant to be heard, with or without legal counsel, and so on. Clear?"

"Clear," said the Newcomer. "And when I am once a licentiate of the Medical Council of Canada, provided I escape having my name erased, I can apply to any provincial licensing authority for a licence to practise in that province. Right?"

"That is correct," They said, "and not only in the provinces of Canada. The qualification of the Medical Council of Canada is recognized in most of the states in the U.S., as well. The licensing authorities have other requirements, in addition, but no further examination is necessary.

"Before we leave the Canada Medical Register, see the way in which your predecessors wrote, not only on the normal sheets but, as well, on the front and back binding sheets of the early books. They were, obviously, saving and careful people as you must be too, if you are to maintain their high standard of performance as you deal with the affairs of the Medical Council of Canada."■

UNIONIZE

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therefore more voters) than there are employers, Ontario's government, for example, was reluctant to enforce the letter of the Hospital Labour Disputes Arbitration Act earlier this year. Is there a case for compulsory arbitration of disputes in the "essential industries"? Perhaps. But try convincing the unions of that.

What can the provincial hospital associations do? Their position is tricky because in theory they represent all sides — management, workers, patients; in reality, however, since their members are corporate entities rather than individuals, the hospital associations are management bodies.

Even so, the Ontario Hospital Association commendably set up its hospital personnel relations bureau in 1969 as a separate and autonomous body to provide reference data to match, according to the OHA's 1973 role study report, "the resources of those provincial, national and international unions which appear on the other side of the bargaining table."

For hospitals, clinics, nursing homes and other health institutions that bargaining table is going to be a permanent part of the furniture — a place where government and physicians or physicians and hospital employers and their staffs will have to talk *with* — not *at* — each other.■

Edinburgh University chair for Canadian studies

Canadians are being invited to contribute to a new venture in Britain which will bind more closely the two nations. The University of Edinburgh is setting up a chair of Canadian studies, financed by the new Canadian Studies Foundation in the U.K.

The Edinburgh University post will cost £180,000 (current exchange rate is $2.30 to the £), of which one third is expected to come from British companies and individuals with interests in Canada, one third from similar Canadian sources and one third is pledged by the Canadian government.

The university has agreed on a three-year curriculum in Canadian studies leading to a B.Sc. in social sciences. First enrolments took place this month.

The foundation hopes to extend its work to other universities as funds permit. Donations may be made through the CMA to the Canadian Studies Foundation, U.K. and are tax-deductible.■